Health Care for the Homeless

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Bibliography #5

Health Care Issues for Elderly Homeless People

January 2003

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Policy Research Associates, Inc. • 345 Delaware Avenue, Delmar, New York 12054
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2002

Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century. **A Quiet crisis in America.** Washington, D.C.: Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002.

This report claims that unmet housing and health care needs will, in the next few years, reach crisis proportions for the growing population of older Americans. Highlighting the dual housing and health care needs of aging Baby Boomers, the report calls for increased attention to seniors' needs and creation of a national policy for affordable senior housing that is coordinated with health and supportive services. Independent living, a secure environment, the accessibility of health care and supportive services, vastly improved coordination of housing and health care with better access to home and community-based services, and the preservation of affordable housing stock are key themes of the report's recommendations.

Eckenfels EJ. **Current health care system policy for vulnerability reduction in the United States of America: A personal perspective.** Croat Med J 43(2): 179-183, Apr 2002.

AIM: To raise questions about how the United States of America, which spends 1.3 trillion dollars on health care, conducts cutting-edge biomedical research, has the most advanced medical technology, and trains a cadre of highly competent health professionals cares for the most vulnerable members of its population. METHODS: Relevant statistical data were extrapolated from the most current statistical sources and research reports, and assessed in terms of existing practices and policies. RESULTS: The data clearly demonstrated that particular population cohorts -- the elderly, the poor, new immigrants, the homeless, the HIV-positive, and substance abusers -- were especially vulnerable to illness and its consequences. CONCLUSION: Since American medicine, despite all of its science, technology, and clinical competence, operates in a non-system, there is currently no efficacious approach to vulnerability reduction. To turn health care in the U.S. into a high quality, comprehensive, and cost-effective system, government officials, health care planners, and medical practitioners must address a series of fundamental social, economic, and political issues. What other countries, like those in South Eastern Europe, can learn from this is not to duplicate these mistakes.

Szerlip MI, Szerlip HM. **Identification of cardiovascular risk factors in homeless adults.** Amer J Med Sci 324(5): 243-246, Nov 2002.

BACKGROUND: Cardiovascular disease is an important health problem among homeless adults; however, the common cardiac risk factors present in this population are unknown. This study was undertaken to identify the reversible cardiovascular risks present in the homeless. METHODS: A retrospective chart review was performed randomly on 100 patients who were seen at a homeless clinic in New Orleans, Louisiana. These patients were compared with 200 matched non-homeless patients who attended an inner-city primary care clinic. Each chart from the 2 groups was reviewed for the presence of hypertension, diabetes mellitus type 2, cigarette smoking, and hypercholesterolemia. Statistical comparisons were made between the homeless and the control subjects. RESULTS: Hypertension was present in 65% of the homeless but only 52% of the non-homeless. Smoking was far more common in the homeless than the non-homeless, 75 versus 57%, respectively. There was no difference in the prevalence of diabetes or total cholesterol. Compared with national data hypertension, smoking and diabetes seem to be represented excessively in the homeless population. CONCLUSIONS: Smoking and hypertension are significantly more prevalent in the homeless population than in a matched cohort. Educational and preventive programs are needed to reduce the prevalence of cardiovascular disease and reduce the overutilization of expensive healthcare resources.

Spiker EC, Emptage RE, Giannamore MR, Pedersen CA. **Potential adverse drug events in an indigent and homeless geriatric population.** Ann Pharmacother 35(10): 1166-1172, Oct 2002.

OBJECTIVE: To identify potential adverse drug events (ADEs) in a geriatric ambulatory population using the modified Beers criteria. METHODS: This is a cross-sectional study of an indigent and homeless geriatric population served by a network of six primary healthcare clinics with clinical pharmacy services. Medical records of patients > or = 65 years old visiting the clinics between Dec. 1999 and April 2000 were retrospectively reviewed by a clinical pharmacist. Medications meeting the modfied Beers criteria were evaluated for the most common drug classes involved, severity potential, and dose or disease state restrictions. Following the identification of medications meeting Beers criteria, the pharmacist left a written recommendation regarding use of alternative drugs or doses in the medical record. Physician acceptance of pharmacy recommendations was also evaluated. RESULTS: Medical records of 146 patients were reviewed. Overall, 52 patients had 70 medications with the potential for causing an ADE based on the modified Beers criteria The most commonly identified medication classes were narcotic analgesics, antihypertensives, and antihistamines. Fifteen of these medications had a high severity potential. Identified medications met the following modified Beers criteria: 41.4% were inappropriate in a specific disease state, 38.6% were inappropriate for the elderly, 10.0% exceeded maximum dosage guidelines, and 10.0% were inappropriate for both the elerly and the patients disease state. Approximately 60% of pharmacy recommendations were accepted by physicians. CONCLUSIONS: The modified Beers criteria are a useful tool for reviewing medical records to identify potential ADEs in an ambulatory geriatric population.

2001

Bottomly, JM. **Politics of health care and the needs of the older adult: The social context of changes in the delivery system.** Geriat Rehab, 16(4):28-44, 2001.

This article addresses two primary issues: the economic status of the older adult and the economic implications of health care. The relationship of elder homelessness is integrated into this discussion as relevant from the literature on the socioeconomic and psychosocial aspects of aging. The emergence of older adults as a substantial subgroup within the United States population has been identified as signaling a crisis for the health care system. This article places recent changes in health care financing for older adults in the context of biomedical, demographic, and social factors that lead to homelessness in an older adult population. These factors, in turn, are related to the larger economic and political structures that have shaped our national health care policies and social programs. Current policies and programs are inadequate in meeting the needs of the growing number of older adults because they provide only a limited array of services. This article examines how the needs of older adults have been portrayed to support age-based entitlements to limit health care coverage, irrespective of need across age strata. All health care practitioners can use their understanding of the genesis of particular public policies to assist in developing a health care system that is responsive to the needs of all members of society (authors).

Bottomly JM, Bissonette A, Snekvik VC. **The lives of homeless older adults: Please, tell them who I am.** Geriat Rehab, 16(4):50-64, 2001.

This article focuses on the personal dynamics of life for older adults who are homeless, at risk of becoming homeless, or who were formerly homeless. It presents older individuals' own concerns and descriptions of the risk of losing a roof over their heads. Conversations describe what it was like for some to actually find themselves homeless, and they describe some of the factors that led them into homelessness. Interviews

provide insight into what it felt like to reside in shelters or on the streets, how individuals became acclimated to this level of existence, and how difficult it was for some to transition from shelter life balk to the security of permanent housing (authors).

Bruckner, J. **Walking a mile in their shoes: Sociocultural considerations in elder homelessness.** Geriatric Rehabilitation 16(4): 15-27, 2001.

This article discusses the sociocultural considerations from an anthropologic view superimposed on a physical therapist's perspective. A historic approach to homelessness in America, starting from colonial times and progressing into the late 20th century, provides a fascinating review of cultural circumstances that lead to elder homelessness. Subgroups of the homeless population such as older homeless veterans, older homeless men, and older homeless women are presented. Discussion revolves around the social dynamics that lead to or prevent homelessness within these subgroups of American culture. Lastly, the changes required in the perceptions and attitudes of rehabilitation professionals in order to adequately meet the needs of homeless elders are provided. Model programs for providing rehabilitative services for homeless populations are presented with an emphasis on physical therapy (authors).

Cohen CI, Sokolovsky J, Crane M. **Aging, homelessness, and the law.** Int J Law Psychiatry 24(2-3): 167-181, May-Jun 2001.

Crane M, Warnes AM. **Older people and homelessness: Prevalence and causes.** Geriat Rehab,16(4):1-14, 2001.

This article examines the prevalence and causes of homelessness among older people. It reviews the histories of a sample of older people in Britain who slept on the streets and stayed in temporary hostels. Some had become homeless for the first time in old age, having been married and worked for many years. Others had spent most of their adult lives in hostels or on the streets. Different events and states triggered and contributed to homelessness at various stages of the life course. Although homelessness generally is associated with shortages of low-cost rented housing, unemployment, and poverty, personal and psychosocial factors had a dominant role as well (authors).

Downes T, Channer KS. **Plight of elderly people who are made homeless in hospital.** BMJ, 323(7306):229, July 2001.

Hwang SW, O'Connell JJ, Lebow JM, Bierer MF, Orav EJ, Brennan TA. **Health care utilization among homeless adults prior to death.** J Health Care Poor Underserved 12(1): 50-58, Feb 2001.

This study characterizes health care utilization prior to death in a group of 558 homeless adults in Boston. In the year before death, 27 percent of decedents had no outpatient visits, emergency department visits, or hospitalizations except those during which death occurred. However, 21 percent of homeless decedents had a health care contact within one month of death, and 21 percent had six or more outpatient visits in the year before death. Injection drug users and persons with HIV infection were more likely to have had contact with the health care system. This study concludes that homeless persons may be underusing health care services even when they are at high risk of death. Because a subset of homeless persons had extensive health care contacts prior to death, opportunities to prevent deaths may have been missed, and some deaths may not have been preventable through medical intervention.

Lewis, CB. **Elder homelessness: Part I.** Geriatric Rehabilitation 16(4): 1-64, 2001.

This is the first of two issues of Geriatric Rehabilitation focused entirely on Elder Homelessness. Articles include: Older People and Homelessness: Prevalence and Causes; Walking a Mile in Their Shoes: Sociocultural Considerations in Elder Homelessness; Politics of Health Care and the Needs of the Older Adult: The Social Context of Changes in the Delivery System; Pro Bono Health Service Delivery to the Indigent: Legal and Ethical Issues and; the Lives of Homeless Older Adults: Please, Tell Them Who I Am.

Technical Assistance Collaborative. **What's wrong with this picture? An update on the impact of elderly only housing policies on people with disabilities.** Opening Doors: Issue 15, September 2001.

The federal government has enacted sweeping changes to federal housing laws which makes it legal to restrict or exclude non-elderly people with disabilities from certain affordable rental housing. Using data from HUD and two federal studies, TAC and the CCD Housing Task Force have recently updated their assessment of the impact of elderly only laws on the supply of federally subsidized housing available for people with disabilities. Specifically, these data and reports indicate that between 268,500 and 293,500 units of federally subsidized housing are currently designated elderly only (authors).

2000

Crane, M, Warnes, AM. **Evictions and prolonged homelessness.** Housing Studies 15(5): 757-773, 2000.

This article examines the connection between homelessness among older people and both evictions by statutory housing providers and repossessions by mortgage institutions. The evidence is from 45 single people who are homeless who reported that eviction made a contribution to their homelessness. Using preceding states and events as criteria, a taxonomy of these one-evicted older people who are homeless is proposed. For the majority, eviction followed a protracted failure to meet their financial obligations or to keep their property in good condition, and for many, mental health problems or exceptionally low competence in basic domestic skills were contributory factors. The experiences of the group strongly suggest that homelessness can be prevented if support is provided to vulnerable people as difficulties mount. Six risk factors for eviction and subsequent homelessness are identified. The article concludes that these markers could be used in experiments to recognize marginally housed people and as a primary prevention measure for homelessness.

Killion, CM. **Extending the extended family for homeless and marginally housed African American women.** Public Health Nurs, 17(5):346-54, Sept-Oct 2000.

Young homeless African American women and elderly marginally housed African American women have health, housing, and personal concerns specific to their age cohort, yet they also have parallel and complementary needs. The young struggle to find affordable housing, while the old may have difficulty maintaining their homes. This article reports select findings from a pilot study designed to describe these two groups of women. The preliminary study was conducted preparatory to the development of a larger study to explore factors that would facilitate or hinder linking the two groups of women for mutual assistance in house-sharing arrangements. Interviews and housing history findings revealed contrasts and similarities among the women and between both cohorts that reflected individual differences, common yet divergent life courses, and collective responses to family life situations, societal trends, and policies. Advantages and disadvantages of house-sharing were delineated with 56.3% of the homeless women and 81.3% of the elderly

women viewing

co-residential living as an option worth considering. House-sharing arrangements should be further investigated by nurses and colleagues. Findings from this study are foundational for establishing alliances that may be a means to promote health and strengthen "family" in both populations.

Rasmussen BH, Jansson L, Norberg A. **Striving for becoming at-home in the midst of dying.** Am J Hosp Palliat Care 17(1): 31-43, 2000.

Research interviews with 12 patients at an inpatient, free-standing hospice in Sweden were analyzed, using a phenomenological hermeneutic approach, to show the effects of individual nursing care as experienced by the guests. The findings revealed that the effects of, and reactions to, nursing care were inseparable from the hospice milieu and the patients' situation, which was interpreted as including the prospect of becoming homeless. Thus, the effects of hospice spirit (nursing care and milieu) as experienced by these hospice patients represented the contrasting possibilities of hindering--or contributing to--the prospect of becoming homeless. What the patients spoke about was either a consoling or a desolating hospice spirit. A consoling hospice spirit supports experiences of wholeness and communion, i.e., becoming at-home in the midst of dying, while a desolating hospice spirit results in feelings of alienation and fragmentation, i.e., feeling homeless. Considering the dying person to be a guest rather than a patient is an important component of Swedish hospice philosophy and supports the view of the dying person as an autonomous and dignified human being.

Warnes, AM., Crane, MA. **The achievements of a multiservice project for older homeless people.** Gerontologist 40(5): 618-626, 2000.

This article reports the achievements of an experimental multiservice center in London for older street people. It begins with reviews of the types of long-term accommodation available for resettlement and the work of its outreach team, 24-hour open access rooms, and residential, assessment, and resettlement services. Two outcomes are examined: (1) whether users returned to the streets; and (2) whether they were resettled in long-term housing. Those with alcohol dependency were most difficult to resettle. Logistic regression analyses of the factors influencing the two outcomes indicate that the duration of residence in the center was the predominant influence (authors).

1999

Cohen CI. **Aging and homelessness**. Gerontologist, 39(1):5-14, Feb 1999.

Aging homeless persons have been largely neglected in the gerontological and homeless literature. This article presents an overview of homelessness and aging within the context of a testable, provisional model for explaining homelessness in this population. The author proposes 16 individual and 5 structural and programmatic variables that contribute to the etiology and sustenance of homelessness among aging persons.

Ettner SL. **The role of the public sector in ensuring access to psychiatric hospital care for elderly and disabled Medicare beneficiaries.** Ment Health Serv Res, 1(1):21-9, 1999.

This article compares Medicare beneficiaries admitted to public, not-for-profit, and for-profit psychiatric hospitals. Administrative data on all beneficiaries admitted to psychiatric hospitals in 1990 were used to

estimate multinomial logit models of treatment in for-profit or private not-for-profit (vs. public) hospitals, controlling for patient characteristics. Women and beneficiaries with worse geographic access to public hospitals, better access to private hospitals, or comorbidities were more likely to be treated in private hospitals. Blacks, rural residents, and beneficiaries who were disabled, had previous hospitalizations, or a primary diagnosis of schizophrenia were less likely to be treated in private hospitals. Residents of lower-income areas were less likely to be treated in private not-for-profits. The authors conclude that in addition to being essential providers for the uninsured, public hospitals also play an important role in ensuring access to care for Medicare beneficiaries. Public psychiatric hospitals treat a disproportionate share of the sickest, lowest-income, and minority patients.

1998

Earnest MP, Grimm SM, Malmgren MA, Martin BA, Meehan M, Potter MB, Steele AW, Zocholl JR. **Quality improvement in an integrated urban healthcare system: a necessary journey.** Clin Perform Qual Health Care 6(4): 193-200, 1998.

Public hospitals and clinics in the United States provide health care for the needs of large numbers of people who are medically indigent, homeless, chronically mentally ill, and suffer medical and social disorders associated with poverty. These "safety-net" healthcare providers traditionally struggle with barriers to providing high-quality, patient-sensitive care, including decaying physical facilities, burdensome bureaucracies, underfunded capital equipment and construction programs, and complex, politically driven budgets and governance. However, these same institutions now must compete for their own Medicaid and Medicare clientele because the private sector is marketing to those patients. They also must continue to provide increasing services to growing numbers of uninsured patients. To accomplish this, these institutions must reinvent themselves as patient-focused, high-quality, cost-effective healthcare providers. The Denver Health system is the public safety-net provider for the city and county of Denver. This large public institution has instituted a multifaceted performance-improvement program. The program includes training employees for patient-focused service, implementing continuous quality-improvement practices, instituting clinical pathways, revising the preexisting ambulatory quality-management program, reengineering key aspects of ambulatory clinic services, and redesigning the hospital-based patient-care services. Major successes have been achieved in some initiatives, but not in all. Many key "lessons learned" may guide others.

Jones JA. **Using oral quality of life measures in geriatric dentistry.** Community Dent Health 15(1): 13-18, 1998.

OBJECTIVE: The purpose of this paper is to present potential uses of existing oral-specific quality of life (OQOL) instruments in geriatric dentistry. METHOD: Selected existing OQOL instruments were reviewed. Three examples of how such instruments have or could be used in geriatric dentistry are presented. CONTENT OF REVIEW: Nine OQOL instruments are briefly reviewed. The potential uses in geriatric dentistry include population applications and uses with individuals for political, theoretical and practical reasons. Practical uses include identification of persons needing treatment, assessing oral health needs in populations and estimating resources required to meet those needs, as endpoints in clinical trials and as measures of the impact of care provided. CONCLUSIONS: The ultimate value of OQOL measures will be measured by their usefulness in improving care of patients. The development of streamlined instruments and a core instrument which can be used in multiple populations and serve as a baseline to which other measures are added is recommended.

1997

Black BS, Rabins PV, German P, McGuire M, Roca R. **Need and unmet need for mental health care among elderly public housing residents.** The Gerontologist, 37(6):717-28, 1997.

This article aims to determine the prevalence of need and unmet need for mental health care for elderly public housing residents. Survey data was gathered from 298 elderly residents of six public housing developments in Baltimore. Thirty-seven percent of this sample needed mental health services, and 58% of those who needed care had unmet needs. The authors suggest there is a need for targeted interventions that would increase service utilization and potentially reduce the likelihood of eviction or placement in more restrictive settings.

Lakhani N. **Alcohol use amongst community-dwelling elderly people: A review of the literature.** J Adv Nurs, 25(6):1227-32, June 1997.

Alcohol use amongst elderly people is an increasingly important area to understand, yet relatively little research has been undertaken and our knowledge remains limited. This paper contains a review of the literature, concentrating on alcohol use in community-dwelling elderly people. Both cross-sectional and longitudinal research papers are reviewed; their findings suggest high abstinence rates amongst the population under consideration, with consumption consistently associated negatively with increasing age and female gender. A summary of the largely non-specific, descriptive literature available is also included. Research concerned with elderly people and alcohol use is problematic and therefore the limitations of the available research are examined in detail. Firm conclusions are difficult to draw from the research to date because, for example, there are varying definitions of terms such as 'alcoholism' and 'heavy drinking' and instruments used for detection have not been validated with older age groups. The need for increased awareness amongst health professionals, especially nurses, about issues surrounding community-dwelling elderly people and alcohol use and misuse is discussed. Finally, the importance of further research, especially amongst largely neglected groups of the elderly population, such as ethnic minority groups and elderly homeless people, is suggested.

Payne D, Coombes R. **Old, down and out.** Nurs Times, 93:16-7, March 5-11, 1997.

Rosen AL, Persky T. **Meeting mental health needs of older people: Policy and practice issues for social work.** J Gerontol Soc Work, 27(3):45-54, 1997.

This article discusses the subject of mental health and aging and addresses factors that create barriers to this population receiving needed mental health services. The authors suggest that the mental health needs of elderly persons are often unmet due to factors such as ageism and stigma, organization of services, and organizational policy issues. The authors discuss efforts to address mental health and aging issues in this country and policy and practice considerations for professionals.

Stolley JM, Koenig H. **Religion/ spirituality and health among elderly African Americans and Hispanics.** J Psychosoc Nurs Ment Health Serv, 35(11):32-8, 1997.

It is important to view elders in a multicultural sense and also understand that there may be great heterogeneity within cultural or ethnic groups. Knowledge of the impact of religion and spiritual beliefs for

ethnic groups can help health care professionals design interventions that are culture-specific to the beliefs of individuals. The psychiatric nurse is in a unique position to encourage the patient to use healthy religious practices to deal with their illness, whether mental or physical.

1996

Alexy B, Elnitsky C. **Community outreach: Rural mobile health unit.** J Nurs Admin, 26(12):38-42, 1996.

With the increased emphasis on cost containment, hospital administrators are investigating community outreach projects to remain economically viable. The authors describe the planning and implementation of a mobile health unit for rural elderly residents. This project represents an alternative model of healthcare delivery in a rural area with limited resources and healthcare providers.

Argentine P. **A healing place.** Boston, MA: Fanlight Productions, 1996 (Videotape: 23 minutes)

This video profiles the staff and residents of William and Mildred Orr Compassionate Care Center, a respite program for homeless and elderly patients who have been released from the hospital, but who are not yet able to manage their own follow-up care on the streets or in their homes. The program documents a humane and effective solution to a growing problem as economic constraints push hospitals to discharge patient "quicker and sicker." AVAILABLE FROM: Fanlight Productions, 47 Halifax St., Boston, MA 02130, (800) 937-4113.

Duffy ME, Bissonnette AM, O'Brien E, Townsend D. **Ending elder homelessness: One city's solution**. J Long Term Home Health Care, 15(4):38-47, Fall 1996.

Heumann LF. **Assisted living in public housing: A case study of mixing frail elderly and younger persons with chronic mental illness and substance abuse histories.** Hous Pol Deb, 7(3):447-71, 1996.

Since the Fair Housing Act of 1988, younger chronically mentally ill and substance abuse residents have been admitted to subsidized senior housing. A purpose of this legislation was to furnish housing for younger homeless individuals and to improve rental income streams for senior facilities. This article describes a Decatur, Ill., study that covered three years of mixing younger individuals into a public housing facility for frail seniors. After the younger persons were admitted, quality of life diminished and management became difficult. Results indicate that careful tenant screening and sensitive and extended management are vital for any chance of successful age integration in subsidized housing.

Kramer BJ, Barker JC. **Homelessness among older American Indians, Los Angeles, 1987-1989.** Hum Organ, 55(4):396-408, 1996.

The authors explain that for decades American Indians of all ages have been over represented among the urban homeless but thus far no studies have examined how homelessness affects elderly American Indians in cities. A survey of 335 older American Indians living in Los Angeles County in 1987-1989 revealed that a large proportion, 16% (n=53), were homeless. Homeless older Americans self-reported higher rates of physical and mental health problems, including hypertension, shortness of breath, diabetes, chest pains, alcoholism, depression, sadness, and loneliness. Of homeless elders who reported usual habitat, all those aged 60 or more years lived on the street year-round; in contrast, 11 of 37 (30%) people aged 60 years or less at least occasionally rented rooms for shelter. Institutional and cultural barriers prevented some homeless individuals from accessing social and welfare services.

Leetun MC. **Wellness spirituality in the older adult. Assessment and intervention protocol.** Nurse Pract, 21:60, 65-70, Aug 1996.

Supporting the spiritual dimension of life is essential to high-level wellness and wholeness. It helps one respond to the potential fullness of life despite problems that arise from illness and longevity. However, health care providers frequently fail to inquire about spiritual well being and thus fail to nurture the spirit. This oversight has especially strong consequences when health care providers treat older adults. This article defines wellness spirituality. It discusses clinical presentation of the conditions in life and illness that indicate that an aging client's spiritual well being is being challenged. Wellness spirituality activities to consider with history taking, both within and outside the context of religion, are outlined. Management approaches are offered to support and restore aging client's ability to achieve spiritual well being. The article also describes virtues clinicians must hold to create a spiritually nurturing environment in all settings. A protocol is offered as a clinical guideline for clinicians to use in their assessment and management of the wellness spirituality of older adults.

Lough M, Schank M. **Health and social support among older women in congregate housing.** Pub Health Nurs, 13(6): 434-41, 1996.

This study of community-dwelling elderly found that perceptions of positive health status and adequate social support do not decline with age, even among the old. The relationship between health status and social support reflects the reciprocal nature of person and environment found in the ecologic model.

Matthew L (ed). **Professional care for the elderly mentally ill.** San Diego, CA: Singular Publishing Group, Inc., 1996.

The book explores new techniques and challenges stereotypes, provides models of care and practical solutions, and brings together the experiences of a multidisciplinary team. The authors address issues that face those working in the services of older people who have mental health problems both at present and in the future, focusing on the potential of the elderly person rather than the problem of diagnosis. AVAILABLE FROM: Singular Publishing Group Inc., 4284 41st Street, San Diego, CA 92105. (ISBN: 0-412-58990-7)

Pynoos J, Parrott T. **The politics of mixing older persons and younger persons with disabilities in federally assisted housing.** The Gerontologist 36(4):518-29, 1996.

This article attempts to explain why mixing the elderly with younger persons with disabilities in government assisted housing attained prominence on the federal housing agenda, the different perspectives of advocates for both populations on the issue, and the implications of the conflict for housing policy and interest group politics. The authors gathered data for their case study by interviewing 11 key participants in the mixed housing issue between August 1992 and March 1993, and by qualitative analysis of a variety of documents. The authors discuss the importance of interest groups for elderly persons working together with other advocates to support policies that ensure affordable and supportive housing for all segments of the population.

Sohng SSL. **Supported housing for the mentally ill elderly: Implementation and consumer choice.** Comm Ment Health Jl, 32(2):135-48, 1996.

The author explains that the development of innovative alternatives to nursing homes is critical, especially in the context of Omnibus Budget Reconciliation Act (OBRA) of 1987 mandates and the growing geriatric population. This article examines the experience of one urban county in Washington state in providing supported housing for the OBRA affected mentally ill elderly. The significance of this demonstration project

is its "bold" new approach in applying this emerging model to the elderly. It illustrates the perspectives and experience of consumers and caregivers.

1995

Ailinger RL, Causey ME. **Health concept of older Hispanic immigrants.** West J Nurs Res, 17(6):605-13, 1995.

The purpose of this study was to explore the health concept of older Hispanic immigrants. In tape recorded home interviews, 54 respondents were asked to define health, describe the characteristics of a healthy older person, identify what contributes to good health, and report what they did to maintain their health. Responses were transcribed and then analyzed qualitatively for categories and themes. Based on the findings, a concept of health evolved that included six major themes: integrating physical, emotional, and spiritual aspects; possessing mental health; feeling well; enjoying independence; practicing self-care; and orienting toward family. These themes will be useful to nurses in planning and implementing health services for similar older Hispanic immigrants.

Community Action Board of Santa Cruz, Inc. **Shirley Mann's story.** The Shelter Project, 10:45 Min, 1995.

In this video, a formerly homeless, elderly woman describes her experience of becoming homeless, living in a shelter, and finally being placed in senior housing. She talks about why she became homeless, the discrimination homeless people experience, the process of acquiring senior housing, and what having a home means to her. AVAILABLE FROM: Santa Cruz Service Center, 501 Soquel Ave., Suite E, Santa Cruz, CA 95062. Phone (408) 457-1741; Fax (408) 426-3345.

Vance D. **Barriers and aids in conducting research with older homeless individuals**. Psychol Rep, 76(3 Pt 1):783-6, June 1995.

Field notes of a qualitative pilot study of older homeless people in Cincinnati identified several barriers and aids to the study of homeless elders. Identified research barriers were researcher's lack of contextual wisdom (street smarts), locating elders, substance abuse, attrition, victimization, credibility of informants, and xenophobia. Identified research aids were friendliness of certain elders, openness of the researcher, attractive incentives in exchange for interviews, and service providers' willingness to share experiences.

Vrabec NJ. **Implications of U.S. health care reform for the rural elderly.** Nurs Outlook, 43(6):260-5, Nov-Dec 1995.

Health care services for elders living in rural areas have been limited by inadequate financing, lack of awareness of existing services, insufficient numbers of providers, and geographic dispersion of rural residents. Not all proposals for health care reform would help reduce these barriers, however. Nurses working in rural areas can facilitate the evolution of the health care system in several ways. A primary mechanism is the development and implementation of nurse-managed centers, networking with existing agencies and services to provide outreach programs to the underserved rural elders. Another mechanism is participation in professional organizations that lobby for rural health concerns. A third strategy is participation in program evaluation and intervention studies with policy-relevant implications. It is an exciting era for nurses involved.

1994

Bissonnette A, Hijjazi KH. **Elder homelessness. A community perspective**. Nurs Clin North Am, 29:409-16, Sept 1994.

Elder homelessness is an increasing problem in our society. After presenting demographics of elder homelessness, this article discusses successful Boston-based program models. Nurse-directed community solutions are emphasized.

Reilly FE. **An ecological approach to health risk: A case study of urban elderly homeless people**. Public Health Nurs, 11:305-14, Oct 1994.

The purposes of this paper are: to describe an ecological approach to assessing health risk, and to apply the approach to a sample of elderly homeless within the context of a single day in a single urban setting. In the approach described, a method of progressive contextualization was used by adding different hazards to the risk profile in a single geographic area. The various hazards were applied to the same time and space frame, that of a 24-hour period and in the urban space used by elderly homeless people. Incorporated into the approach are the concepts of high-risk areas and space-time geography, and the theory of disease ecology. The spatial-temporal distribution of resources, factors in the natural environment (patterns of daylight and dark and ambient temperature) and factors in the human-created environment (traffic and crime patterns) were identified as important hazards within the urban environment. Homelessness itself, the effects of aging, the social milieu, and behavior patterns commonly seen in homeless people--particularly, alcohol abuse--were identified as important hazards for elderly homeless people. Each hazard's spatial-temporal pattern within the 24-hour period is discussed. Then the convergence of hazards forming an interactive effect is discussed. Finally, approaches to nursing interventions aimed at reducing risk are presented.

Tully CT, Jacobson S. **The homeless elderly: America's forgotten population.** J Gerontol Soc Work, 23(3/4):61-81, 1994.

The authors explain the number of older Americans who are homeless is growing at a rapid rate. This article presents a review of the literature that examines the three primary causes of homelessness in the older population: (1) deinstitutionalization; (2) poverty; and (3) lack of affordable housing. Other issues discussed are legislative responses to this growing social problem, and implications for professional social workers.

Vance D. **Barriers to use of services by older homeless people.** Psychol Rep, 75:1377-8, Dec 1994.

In this study, participant observation was used by a volunteer at a homeless shelter in the Greater Cincinnati, Ohio area in order to determine the level of service utilization among a group of elderly homeless individuals. Findings indicated that these older homeless individuals avoided services they deemed unsafe, such as shelters which provided little protection by staff. In addition, although knowledge of services was clear, elderly homeless persons would forego services they perceived as a waster of time and effort, such as job training and employment services.

1993

Burr DW, Rich T (eds.). **Old and homeless: A guide to working with older homeless adults.** Tampa, FL: Florida Mental Health Institute, University of Florida, 1993.

This is a training guide for staff and volunteers working with elderly homeless individuals. Topics include: labels and social context; mental health problems; substance abuse; physical health; medications; outreach; and community resources and housing. AVAILABLE FROM: Diane W. Burr, Florida Mental Health Institute, Dept. of Aging and Mental Health, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899.

Closser MH, Blow FC. **Recent advances in addictive disorders. Special populations. Women, ethnic minorities, and the elderly.** Psychiatr Clin North Am, 16(1):199-209, March 1993.

The term special populations in the field of substance abuse refers to groups of patients who have unique treatment needs or who are underserved. This article reviews recent advances in substance abuse among three special population groups: women, ethnic minorities, and the elderly. The prevalence, problems with identification, issues in treatment, and treatment outcomes of substance abuse are discussed separately for each group. Finally, the heterogeneity of characteristics within each special population group is emphasized.

Cohen CI, Onserud H, Monaco C. **Outcomes for the mentally ill in a program for older homeless persons.** Hosp Comm Psych, 44(7):650-6, July 1993.

OBJECTIVE: The study evaluated the success of a generic service program for older homeless persons in improving the well being of mentally ill clients. It attempted to identify factors that predicted the number of service encounters and outcome in seven areas, including housing, entitlements, physical and mental health, and sobriety. METHODS: All persons newly admitted to the program during a two-and-a-half-year period were asked to participate in structured interviews assessing their physical and mental health and their support networks. Two-thirds of those eligible (130) participated in the intake interviews. At three-year follow-up or last contact, outcome was compared for 41 psychiatric clients with psychotic symptoms or self-reported history of psychiatric hospitalizations and 89 clients with no psychiatric symptoms or previous hospitalizations. RESULTS: Persons with mental illness averaged 2.5 favorable outcomes, and a majority obtained temporary or permanent housing, improved their physical health, and secured entitlements. However, mentally ill clients had significantly fewer service encounters and favorable outcomes than clients who were not mentally ill. CONCLUSIONS: A generic service program for older homeless persons can successfully improve the well being of mentally ill clients, although outcomes are less favorable for such clients than for clients who are not mentally ill.

Coyne AC, Gjertsen R. **Characteristics of older adults referred to a psychiatric emergency outreach service.** J Ment Health Admin, 20(3):208-11, 1993.

This article presents the findings of a study that reviewed characteristics of elderly adults referred to a psychiatric emergency outreach service in Piscataway, New Jersey. The results indicate that the percentage of requests for emergency screening services involving adults aged 60 or older was greater than rates of utilization among the elderly of non-emergency community mental health services. According to the authors, this apparent overrepresentation of older adults utilizing psychiatric emergency services echoes the findings of previous studies and highlights the limited options available for mental health care of older adults.

Crane M. **Elderly, homeless and mentally ill: A study**. Nurs Stand, 7:35-8, Dec 16-Jan 5, 1993.

This article describes a study of people aged 60 and over who were homeless and sleeping on the streets in Central London. The author spent 334 hours on the streets of London between July and October 1990, and attempted interviews with 130 elderly homeless people before finding 50 who were able to give a full interview. Information about this client group was then collected, including mental health problems they reported or that were observed during the interviews. The results suggest that the link between mental health problems and homelessness among elderly people may be profound.

Elias CJ, Inui TS. **When a house is not a home: Exploring the meaning of shelter among chronically homeless older men.** Gerontologist, 33(3): 396-402, June 1993.

This study explored the world of 35 chronically homeless older men in downtown Seattle, with special attention to their experience of shelter and its effect on health-seeking behavior. We found that their experience of shelter is intertwined with their perceptions of self and use of alcohol. For many, the public shelter provides safety, support, community, and an opportunity to regain sobriety--attributes of shelter often unattainable in single-room occupancy hotels--but only temporarily.

Governor's Inter-Agency Task Force. **Report of the governor's inter-agency task force on mixed populations in elderly and disabled housing.** Boston, MA: Governor's Inter-Agency Task Force, 1993.

On July 19, 1993, Governor Weld vetoed a move to cap the number of disabled individuals who could reside in state-supported public housing for the elderly and disabled. An inter-agency task force was convened to report to the Governor on the issue of mixed populations in elderly and disabled housing. The report includes an extensive and comprehensive set of recommendations and outlines the process that will be utilized to implement realistic long-term solutions to this issue.

Harper MS, Lacey BM. **Mental health/mental illness of the elderly who are homeless**. ABNF J, 4:45-9, Spring 1993.

In the United States, 6,000 people become 65 years of age each day, becoming a part of the 30 million persons, or 13% of the U.S.A. population, that is 65 or over. The U.S. Census Bureau has estimated that, by the year 2050, more than 100 million will be 55 or older, and that 30 million will be older than 75 (American Association of Retired Persons [AARP], 1991). This article describes the recent research on the prevalence of the homeless elderly, with emphasis on their mental health/mental illness.

National Resource Center on Homelessness and Mental Illness. **Creating community: Integrating elderly and severely mentally ill persons in public housing.** Washington, DC: U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services, 1993.

This report reflects the collaboration between the housing and mental health services fields that is required to meet the needs of persons with mental illnesses who are living in public housing for elderly families. The information is designed to help management and staff of public housing authorities (PHAs) and community mental health agencies seeking ways to effectively integrate younger individuals with mental illnesses into public housing. The information was gathered in early 1992 from PHAs and mental health agencies that have established formal programs to address the challenges inherent in providing services to younger persons with mental illnesses living in public housing for elderly families. The eight PHAs that form the basis for this report are located in Boston, MA; La Salle County, IL; St. Paul, MN; Danbury, CT; Providence, RI; Seattle, WA; Rockford, IL; and Toledo, OH. AVAILABLE FROM: The National Resource Center on Homelessness and Mental Illness, 262 Delaware Avenue, Delmar, NY 12054 (800) 444-7415.